The Changing Character of the Medical Profession: A Theoretical Overview

DONALD LIGHT[1] and SOL LEVINE[2]

[1] *University of Medicine and Dentistry of New Jersey;*
[2] *Boston University*

AT THE VERY TIME WHEN PHYSICIANS CAN DIAGNOSE the inner reaches of the brain with magnets, disintegrate kidney stones using sound waves instead of scalpels, and command an increasingly impressive technology, the profession is feeling besieged (Stoeckle 1988). Although trust and respect are still in evidence, malpractice suits abound. The institutional and technical character of medical work has become so complex that it threatens to make physicians an appendage to rather than master of their technology (Arney 1982).

Perhaps of even greater significance, the medical profession is no longer exempt from antitrust law (Rosoff 1979), a change implying that disinterestedness is no longer perceived as the distinguishing difference between doctors and businessmen, as Talcott Parsons (1954, 34–49) maintained in 1939. Health care corporations (which appear now to include most old-fashioned community hospitals) are openly concerned about profits or surpluses, and the front office monitors the financial performance of clinicians with increased stringency. Meanwhile, nonhealth corporations have rebelled against the escalating premiums for health insurance (Goldsmith 1984; Fruen 1986; Gabel et al. 1987). Joined by Medicare, Medicaid, and other institutional buyers, they

The Milbank Quarterly, Vol. 66, Suppl. 2, 1988

have initiated a wide range of programs to manage costs, utilization, quality, and, ultimately, physicians.

This paradox of medical advances and professional decline calls for analysis. A prevailing concept since Eliot Freidson (1970a, 1970b) developed it in 1970 has been that of professional dominance. Throughout the 1980s, Freidson (1984, 1985, 1986a, 1986b) has maintained that despite all the implicit and explicit assaults on the profession, physicians still dominate medicine either individually or collectively. Even when individual physicians find themselves in subordinate roles, other physicians will be managing them or shaping their management.

Three alternate and quite distinct concepts that challenge this perspective by reflecting recent social developments are (1) deprofessionalization, with its connotation of consumer revolt and profound cultural change, (2) proletarianization, with its emphasis on the inevitable expansion of capitalist exploitation, and (3) corporatization, with its tragic sense of swallowing up professional work.

Finding concepts that characterize what is happening does matter, because good concepts capture essences, identify dominant forces, determine our focus, and suggest future direction. In this article, we provide a brief overview and assessment of Freidson's concept and the three alternatives. We then provide an historical overview that shows how the profession's long campaign for autonomy and dominance contributed, ironically, to a reversal in its fortunes.

Alternate Concepts of the Medical Profession

Professional Dominance

Theories and concepts about the professions tend to reflect the norms and outlook of their time (Light 1988a). In his essays, Talcott Parsons (1951, 428–79; 1954, 34–49, 50–68) recast the medical profession's norms about how doctors and patients should behave into normative sociological theory purporting to describe how they do behave. Most of medical sociology, working comfortably within the profession's construction of reality, followed his lead, but Eliot Freidson (1961) challenged the tenets of normative theory. He was one of the first to recognize conflict and complexities in doctor/patient relationships. At the larger level, his theory of professional dominance challenged

the normative concepts of Parsons about the nature of the profession. For example, normative theory held that professional training differed from others in being prolonged, specialized, and theoretical. Freidson provocatively asked *how* prolonged, *how* specialized, and *how* theoretical must it be to qualify as "professional"? Professions were said to be special in their service orientation, but how might one measure the difference between this orientation and that of a waiter or myriad other service "professionals"? What distinguishes the professions, or at least the profession of medicine, Freidson concluded, was its dominance over its sphere of work.

In his original formulation, Freidson (1968, 1970a, 1970b) discusses several vehicles for establishing professional dominance. One is autonomy over work. This seems necessary but not sufficient for dominance; many occupations have autonomy over their work without having much power. A second is control over the work of others in one's domain. Such control provides power well beyond autonomy, but it implies bureaucratic structures (like hospitals), and bureaucracies have a way of generating their own sources of power through regulations and hierarchy. Yet another source of professional dominance lies in the cultural beliefs and deference that people exhibit toward doctors as healers. This credibility is reproduced in the class hierarchy, institutions, and culture of medicine (Navarro 1976, 1986; Waitzkin 1983). We would argue, as did Jacques Barzun (1978), that culture is the most fundamental source of professional power; but it is subtle, intangible, and may shift the ground from under the feet of the profession as deference is replaced by wariness.

A final source of professional dominance is institutional power. Perhaps the most coherent formulation of the theory of professional dominance would center on Weber's analysis of social authority: a profession parlays its claim of valuable and complex knowledge into cultural and legal authority and thence into institutional authority (Freidson 1968; Light 1974). Each advance in authority provides new resources for further extensions of its dominance (Lieberman 1970).

Freidson pointed out the problems produced by medical dominance. Because of it, physicians tended to practice where they wanted, resulting in maldistribution and the underservice of millions. Taking on the mantle of *individual* autonomy, physicians frustrated any effort by the profession to monitor the quality of their work as expected by society by granting the profession *collective* autonomy. These and other dimensions of Freidson's wide-ranging critique were backed by research, some of

it by Freidson himself, and conveyed a sense of inevitable hegemony (Waitzkin and Waterman 1976). Ironically, just as Parsons's "universal" theory of the medical profession captured the uncritical admiration of doctors in the prewar and postwar era, so Freidson's theory of professional dominance captured that mixed sense of awe and resentment that people felt toward the medical profession (and other large institutions) during the Vietnam years (Light 1988a). Freidson's theory outlined a dynamic of ever-increasing dominance that almost precluded decline.

By 1985, Freidson had narrowed the original multifaceted concept of professional dominance to that of control over subordinate health workers and the power of licensure. Despite the assault from the women's health movement, the consumer health movement, the emergence of for-profit corporations, the pressures of cost containment, the changing patterns of medical work, the rise of health maintenance organizations (HMOs), the growing supply of physicians, and the growth of competition, Freidson maintained that the profession remains dominant because it is still legally empowered to make decisions and oversee the medical work of others. Be that as it may, the situation begs for a reformulation that encompasses some of the most profound changes in half a century.

There is great opportunity to investigate the changing nature of autonomy, of doctor/patient relations, of institutional power, and of control over the medical division of labor. Each of these aspects needs to be researched by speciality and by institutional setting, for the profession is far more differentiated than before. Of particular interest are physicians who design and/or carry out systems that review physicians' practices, or computer systems that make diagnoses more accurately than the average specialist (Barnett et al. 1987; Rennels and Shortliffe 1987; Shortliffe 1987; Goldman et al. 1988). Equally important would be research on the extent to which nonphysicians and nonmedical institutions affect the management, monitoring, and clinical work of physicians (King and Skinner 1984; Ricks 1987; Inlander 1987; Ollier 1987; Aquilina, Daley, and Coburn 1987).

Deprofessionalization

At about the same time that Freidson perceived the growing excesses and imbalances of professional dominance, Marie Haug (1973) described

the beginnings of deprofessionalization. Reacting against the fashionable idea among intellectuals that soon nearly all of postindustrial society would be professionalized (Bell 1973), Haug argued that deprofessionalization would be the trend of the future. Specifically, she defined it as the professions losing "their monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over the client" (Haug 1973, 197). Her wide-ranging and suggestive essay discussed new aggregations of professional specialization, such as family medicine, and new configurations of work manifested in the proliferation of paraprofessionals, such as physicians' assistants.

Other forces weakening the dominance of professions, she noted, were the diffusion of knowledge through computers, increased literacy, and the rising dissatisfaction among laymen with professionals who were self-serving rather than client-serving. Haug (1973, 206–7) predicted that "the tension between the public demand for accountability and the professional's insistence on final authority has not yet erupted into general warfare. . . . But there have been skirmishes." As the ideology grows worldwide that professionals' decisions are subject to lay questioning, and as professional charisma dims, such challenges to expert authority and autonomy can be expected to occur with increasing frequency. In this sense the bureaucratization of professional practice carries with it the seeds of its own destruction. Since her initial essay, Haug has explored this theme in greater depth (Haug 1976; Haug and Lavin 1981). Her 1976 survey with Bebe Lavin (Haug and Lavin 1983) showed that a sizable minority of citizens said they were willing to challenge physicians' authority and participate in decision making.

Freidson (1985) dismisses much of the deprofessionalization argument. He believes that most if not all of the consumer health movement little affects physicians and that the public confidence in doctors has declined no more than for other prestigious groups. He is unimpressed with the alleged closing of the knowledge gap as patients become more educated, because the growth of complex knowledge accumulates at an even faster pace. The pre-eminent legal and institutional dominance of the profession remains intact.

Although Haug has identified several profound changes that no future assessment of the medical profession can ignore, we need systematic analysis of existing evidence and carefully designed studies that examine the ways in which the medical profession is being affected by the

forces she described. The women's health movement and the consumer health movement initiated a significant cultural shift that has changed health habits in the United States, fostered new lines of business to manage risk factors or promote health, and even altered the practice of medicine in some quarters. Computerization is breaking down strongholds of professional dominance. Freidson may be correct that a small group of physicians helps to develop these programs, but the net effect is to rationalize professional skills so that physician performance can be subjected to external evaluation. Computerized systems that compare medical practices serve to define the norms of acceptable practice at the same time as they identify deviant practitioners (O'Donnell 1987; Feldstein, Wickizer, and Wheeler 1988). A systematic review could probably make a good case for deprofessionalization since 1970, and even the profession's legal and institutional prerogatives no longer remain intact.

Proletarianization

A provocative effort to understand the institutional changes affecting physicians centers on the debate between some Marxists, Weberians, and liberal intellectuals about the nature of professional work in advanced economies. Daniel Bell's (1973, 1976) description of the postindustrial society, in which knowledge replaces capital as the central factor of production, has been dismissed as naive by proletarianization theorists. They emphasize the role and relations of professionals to capital and to other classes. They see parallels between the "deskilling" and "routinization" of craftsmen in the nineteenth century and what is beginning to happen to professionals since the mid-twentieth century (Aronowitz 1973; Oppenheimer 1970, 1975; Larson 1977; Derber 1982). Technological developments have increased requirements for capital, forcing professionals to depend on capitalists for supplies and equipment. As this dependency grows, so does the power of capitalists to shape "production." Will professionals experience the final step of having their craft knowledge subsumed into new industrial technology so that their craftmanship is no longer needed, or will they retain a fair degree of control over the technical aspects of their professional work?

There is no question that many doctors feel imposed upon, compromised, and controlled from all sides (Block 1988; Scovern 1988).

As John McKinlay (1977) outlined in a provocative review of Freidson's work, there is a logic to capitalism that drives it to find new markets and expand, and then to plow the profits into further expansion and into creating through advertising a demand or a craving for more commodities. Implanting unnecessary pacemakers, the boom in plastic surgery, and persuading patients with terminal lung cancer to undergo surgery for profit are some recent examples of a long-standing trend (McCleery et al. 1971; Waitzkin 1983; Greenspan et al. 1988; Greenberg et al. 1988). McKinlay went on to fault Freidson for not addressing the relations between the medical profession and capitalism, the class interests behind professionalism, the political/economic consequences of medicalization when medicine has only a modest impact on health, and the relation between the medical profession and capitalism.

By 1985, McKinlay and his colleague Joan Arches sharpened part of this larger argument in an article on the proletarianization of physicians that has generated controversy (Roemer 1986; McKinlay and Arches 1986; Chernomas 1986). The expansion of capitalism, they argue, has induced more bureaucracy as its principal form of social control. Increasingly, physicians take salaried positions in bureaucratic organizations where regulatory norms and administrative hierarchy shape the delivery of medical care. McKinlay and Arches add that the rapidly growing number of physicians weakens their market power and strengthens the bureaucrat's power to set terms. The recent emphasis on technological training makes graduates dependent on large organizations. The emphasis on "value neutrality" or "detached concern" in professional training fits well into the dehumanized approach of bureaucratic medicine. Specialization and subspecialization carry the seeds of "deskilling"—a key capitalist technique for paying workers less, making them more replaceable, and extracting more surplus value out of their labor.

This formulation has been valuable in focusing attention on important developments, but it must also be remembered that physicians have been energetically pursuing specialization since the turn of the century in order to realize more income, greater prestige, and more interesting work (Stevens 1971). There seems to be no evidence that physician specialization has been the basis for "deskilling" or lower income. In fact, many physicians have ardently pursued technological advances and ordered the latest medical devices in order to advance their clinical skills, meet the demands of patients, and increase their income. It

is not clear how the proletarianization perspective explains the millions of unnecessary procedures, prescriptions, operations, and hospitalizations that have led Congress and major corporations to seek controls over physician-induced expenditures (Rensberger 1988; Chernomas 1986).

Three major changes underlie the proletarianization argument: the increasingly technical and organizational complexity of modern medicine, which is found in socialist countries as well as in capitalist societies (Larkin 1983; Light and Schuller 1986); the rise of investor-owned health care corporations, particularly hospital chains (Light 1986) which tend to attract physicians with more amenities and institutional support or risk losing them to nonprofit competitors (Shortell 1983; Shortell, Morrisey, and Conrad 1985; Alexander, Morrisey, and Shortell 1986); and the revolt of institutional buyers who seek to control the rising cost of services. These three changes are best discussed on their own terms. Moreover, there is the question of how apt the concept of proletarianization may be (Derber 1982, 1983; Navarro 1988). Navarro holds that the concept of "proletariat" refers to supervised manual workers who do not have control over the means or organization of production. Even if this strict definition among Marxist scholars were somewhat broadened, one doubts that it would apply to physicians since their powers remain substantial.

Other writers concerned about these issues have moved beyond proletarianization in their effort to understand the place of professionals and other mid-level groups in modern society (Ehrenreich and Ehrenreich 1977; Carchedi 1977; Poulantzas 1975; Wright 1978, 1985; Derber 1982, 1983; Oppenheimer 1985; Burris 1987). They view the term "proletariat" as inappropriate and have been searching for a new concept that depicts the role of professionals and managers employed by corporations. Although physicians and students of health care do not generally read this literature on social class, it addresses more thoughtfully than any other the basic questions of professional identity in an age of corporate (i.e., capitalist) health care.

Most of these authors share the problem of treating managers and professionals together, when their relations to the mode of production and to capital are quite different. They are not focused on highly paid professionals who can be exploited to produce significant surplus value for the owners of a corporation. Nor do they distinguish front-line physicians on salary, who supervise only their nurse and a couple of staff as they treat patients, from a medical director, who supervises

a large staff with an eye to the bottom line. A third group, physician-entrepreneurs are also not discussed, but they pose little problem: they are budding capitalists.

One neo–Marxist concept is the "professional-managerial class" (PMC) introduced over a decade ago by Barbara and John Ehrenreich (1977, 13, 18). It consists of "salaried mental workers who do not own the means of production and whose major function in the social division of labor may be described broadly as the reproduction of capitalist culture and capitalist class relations." The fundamental differences between the PMC and classic petty bourgeoisie reflect the underlying change experienced by physicians who have gone from being self-employed professionals to professionals in corporations. As petty bourgeoisie, self-employed physicians have been structurally outside and therefore "irrelevant to the process of capital accumulation and to the process of reproducing capitalist social relations." But once in the corporation, they are involved in both.

The Ehrenreichs hold that the PMC is essentially "nonproductive" and paid from the surplus value gained from the exploitation of workers elsewhere in the corporation. This may be true of the company doctor (Walsh 1987) but not of physicians working for health care corporations. They are high-class workers who may be exploited but still retain considerable control over the means of production, like craftsmen in the first stage of proletarianization when capitalists bankrolled their financial needs but left them alone to turn out valued products. From a theoretical perspective, whether or not professional services produce surplus value depends on ownership and the structure of pricing that frames the services (Larson 1977, 213–14; Chernomas 1986, 672; see also other articles in the *International Journal of Health Services*).

Another insightful line of analysis beyond proletarianization is found in Erik Olin Wright's (1980) ideas about professionals in "contradictory class locations." As applied to doctors, examples would include employed physicians as located between the working class and the petit bourgeoisie, and physicians running group practices as located between the petit bourgeoisie and capitalists. More recently, Wright (1985) has explored the ways in which class position depends on exploiting the rights to other kinds of property involved in production such as skills, special knowledge, and the organization of work. Thus, while a much more differentiated analysis remains to be done on how different types of

medical careers relate to capital, surplus value, and the means of production, this body of work goes well beyond the proletarianization perspective to identify the structural relations between physicians, workers, and owners of corporations.

Corporatization

To a significant degree, corporatization encompasses the proletarianization thesis without the same Marxist assumptions (McKinlay and Stoeckle 1988). It refers to the experience of being subjected to forms of corporate control—such as utilization and quality review, incentive pay structures, restrictions on practice patterns and the organization of practice, and the restructuring of the marketplace from solo or small-group providers to multi-institutional complexes (Burnham 1984; Stoeckle 1988; Block 1988; Scovern 1988). These are the experiences not just of the working class but of managers as well (Larson 1980). Corporatization also refers to the paradox of physicians relying on complex organizations and financial arrangements to carry out their sophisticated work, yet realizing that these institutions intrude on their work, mediate their relations with patients, and potentially injure their credibility with society as a whole. Legitimacy is both extended and threatened.

Again, a sorting-out is in order. To what extent are the long-standing complaints about rationalization and bureaucracy (Saronson 1977) being attributed to "corporatization"? The traditional emphasis on autonomy and independence makes American physicians ill-prepared to enter the organizational structures of the modern industrial world (Rueschemeyer 1986, ch. 6). Yet even though corporatization may be rationalization and bureaucracy in contemporary garb, it does bring with it what Derber calls (1982, 169–87) "ideological proletarianization." By this he means losing control over the product or *ends* of one's work while maintaining control over the *means* or techniques of work.

Derber believes that most professionals accommodate to ideological proletarianization. They will desensitize themselves to the issue by disassociating themselves from the goals of the institution and/or by denying that control over the product of their work is all that important. What matters is that one does one's work well. Physicians, like other professionals, are trained to make an end out of means as a way of resolving troublesome sources of uncertainty (Light 1979). They then

may take the second step of identifying with the goals of the institution. At the same time, the professionals provide a valuable source of legitimation for the organization.

Logically, the term corporatization should also encompass the development of the corporate impulse *within* the profession (Goldstein 1984; Relman 1985). Professional corporatization has become widespread as physicians unbundle services from hospitals and turn their offices into capital-intensive ambulatory centers for diagnosis and treatment. Thus, corporatization is a concept worth pursuing, but in a way that recognizes its two-sided nature.

The impact of these developments on consciousness, work, and the profession are often described but not yet deeply understood. Important research needs to be done on how the new corporate structures affect professional work without romanticizing the degree of autonomy that physicians had in the "good old days" of private practice. What kinds of control and dependency did small, private practitioners have, and what kinds do physicians today have in nonprofit and for-profit HMOs, PPOs, hospitals, and medical departments of corporations? What kinds of institutional arrangements most expose medical decisions to, or protect them from, corporate priorities? In different institutional arrangements, the relation of physicians in different positions to capital and profit (broadly defined) needs to be fully described.

In conclusion, each of the four concepts discussed in this section illuminates important developments in modern medical practice; yet, each reflects a theoretical and political perspective that captures only part of a larger whole. What follows is a historical perspective that shows how developments characterized by deprofessionalization, proletarianization, and corporatization are not entirely exogenous to but were facilitated by unanticipated consequences of the professional dominance which the medical profession attained.

Professional Dominance and Corporatization

The rise to professional dominance of the "regular" or allopathic sect has been well documented by a number of scholars (Burrow 1963, 1977; Berlant 1975; Rothstein 1972, 1987; Stevens 1971; Larson 1977; Starr 1982). Only a few salient points need emphasis here. The development of a coherent autonomous profession, or what Larson

(1977) calls "the professional project," was in part aimed at *preventing* medical work from being controlled by corporations near the turn of the century. Already, the railroads, the lumber industry, mining companies, and some textile mill towns employed or retained thousands of "company doctors" (Starr 1982, ch. 6). Less well known were a growing number of regular companies as well as governmental departments and fraternal societies who put out medical service contracts for bids, often on a capitated basis (Henderson 1909; Ferguson 1937; National Industrial Conference Board 1923). Reports from various cities estimated that a quarter to a third of the population obtained services under competitive contracts. To put the matter more abstractly, institutional buyers were structuring wholesale markets before 1910.

More than has been realized, the profession's drive for autonomy and control involved wresting control from institutional (i.e., corporate and governmental) buyers, minimizing competition, and eliminating forms of cost containment. Besides reinstating medical licensing boards, using their examinations to institutionalize the new scientific curriculum, and using the new curriculum to drive many medical schools out of business with the demands of the new curriculum, leaders of medicine campaigned intensively against "contract medicine." State and county societies urged members not to bid against each other for the contracts and threatened expulsion if they did. The profession succeeded in getting employers and other contractors to stop providing direct services and instead to help pay the bills of autonomous doctors. The profession also inveighed against the free care provided by dispensaries and by the leading public health departments (Burrow 1977). At the same time, physicians were extraordinarily successful in obtaining capital for their own professional purposes. They professionalized hospitals and used them both to develop their skills further and to increase their fees (Rosner 1982; Vogel 1980; Rosenberg 1987).

What the profession sought was a precapitalist guild in the middle of a capitalist society. Leaders understood that if they could get physicians to unite against competition everyone would win. As Max Weber (1968, 46, 342–46) wrote, guilds are a form of closed order which pursues quality, prestige, and profit to the mutual benefit of its members. Weber's description captures essential elements of professionalization (Carr-Saunders and Wilson 1933, 298–364; Scull 1979). As Larson (1977) put it, the profession *gained* autonomy, *created* ideology—which it presented as the most valid definition of reality—

and *monopolized* competence. Professionalization, she writes, is "the process by which producers of special services sought to constitute *and control* a market for their expertise" (Larson 1977, xvi). It is neither inevitable nor "natural" (Kennedy 1954).

By the 1920s, the medical profession had gained control of its markets, mode of practice, training, and institutions (Rayack 1967; Burrow 1977; Starr 1982). The rapid growth of hospitals built by doctors, religious orders, charitable organizations, and community donations not only gave physicians a technical workshop but also provided a way of disciplining errant colleagues by not granting privileges unless they were in "good standing" with the local medical society. The sponsors who provided immense amounts of capital, however, did not control the profession (Derber 1983). Although forms of contract medicine continued, they now existed only at the periphery and faced fierce opposition from local societies. Complete control by the guild seemed possible until the Depression perpetrated a crisis in how to pay for services. New forms of prepaid contracts arose among companies, hospitals, medical societies, volunteer associations, and governments. They sought through various types of subscription and payment mechanisms to cover the high costs of those few who became ill (Williams 1932; Avnet 1944).

The AMA remained adamantly opposed to any arrangement that put a middleman between doctor and patient, but the hospitals were more desperate (Leland 1932). The American Hospital Association selected one from the wide range of plans in operation that met their requirements: no profit, no middlemen, no interferences with the practice of medicine, noncompetitive, and confined only to hospital bills so opposition from medical societies could be avoided (Rorem 1940). It is commonly believed that Justin Ford Kimball, at Baylor Hospital, came up with just the right plan that would solve the fiscal crisis of American hospitals (Fein 1986, 10), but we must remember that other hospitals created prepaid plans. More important, comprehensive forms of prepaid health insurance were passed over and later vigorously opposed (Burrow 1963; Rayack 1967).

There followed a sustained and difficult campaign to forge competing hospital prepaid plans into area-wide noncompetitive plans, to foster the creation of such plans where they did not exist, and to create a legal basis for provider-controlled, nonprofit, noncompetitive, community health insurance for those who could afford the premiums.

Named Blue Cross, this partial form of social insurance was designed to minimize any middleman role by giving control of the plans to physicians and hospital administrators or trustees. Some years later the physicians decided to follow suit with Blue Shield along similar but not exactly parallel lines.

Instituting health insurance along professional lines and defeating prior efforts to legislate national forms of social insurance completed "the professional project" (Larson 1977). The results are captured by Freidson's term "professional dominance": a health care system whose organization, laws, and financing reflect the priorities of the medical profession to provide the best clinical medicine to every sick patient, to enhance the prestige and income of the profession, and to protect the autonomy of physicians (Light and Schuller 1986, 14–17). The profession has both used state powers throughout its history to pursue its goals and feared state intervention as a threat to professional autonomy. In fact, the American case is distinguished from many other countries by the reluctance of government to intervene (Larkin 1983; Willis 1983; Coburn, Torrance, and Kaufert 1983; Wilsford 1987).

Professionalism in a Corporate Society

The influence of corporations on the medical guild occurred in more subtle and indirect ways. Through licensure and guild rules, the profession and created protected markets allowed health-related corporations to enter into those markets. Although today we tend to think of this happening with corporations involved in direct services such as hospital corporations or HMOs, the earliest and perhaps most important instance involved the profession creating an "ethical" (i.e., in conformity with AMA ethics about professional control) drug industry (Burrow 1963; Rorem and Fischelis 1932; Caplan 1981). As early as 1906, the AMA mounted a vigorous campaign against nostrums and patent medicine. The profession, joined by druggists who were also feeling the competition from patent medicine manufacturers, sought to cordon off and control the sale of only those drugs whose recipes were revealed, tested, and approved by the AMA. Aside from many other facets of the story, this created a protected professional market. Since the profession opposed any state participation, and capitalism constituted the "natural" economic environment of the

nation, it was inevitable that "ethical" drug companies experienced tremendous growth and profits. What the profession did not anticipate is that these same corporations would come to influence professional judgment and make many facets of professional life dependent on them (Goldfinger 1987; Lexchin 1987; Mintz 1967).

Over subsequent decades, corporations have flourished in every other sector of the protected medical market—hospital supply, hospital construction, medical devices, laboratories, and insurance—until the only large sector left untouched was medical service itself. Physicians somehow thought that they could allow corporations to dominate all these other sectors without being touched themselves. Yet ironically, their judgments and decisions were being commercialized in numerous ways—by how insurance policies were written, by what medical devices were promoted, by how supplies were packaged, by what new lab tests were made available, by which company sponsored professional presentations, and by which salesmen they saw. Thus, the rise of corporate *providers*, though regarded in the profession as a shocking radical departure (Relman 1980), was very much an organic part of the profession's long-term relation with capitalism.

The other aspects of corporatization that result from bureaucratic complexity also evolved in part as a natural consequence of professional dominance. The profession's emphasis on elaborated techniques and specialization led to more complex organizations of work and finance, with a given physician only part of a larger complex. In order to manage large hospitals and health centers, administrators became more professionally qualified and powerful. Thus, administrative control and bureaucratic rules grew steadily after World War II, well before the current era of large health care corporations. These new corporations have further extended bureaucratic tendencies, but they have also catered to physicians (Shortell, Morrisey, and Conrad 1985).

The proletarian perspective alludes to similar features and developments which ironically accompanied the profession's drive for autonomy and dominance. In addition, the relentless rise of medical expenditures for every test and procedure ordered to "provide the best clinical care regardless of cost" has led institutional buyers to impose new mechanisms for accountability. Recent developments include physician practice profiles, utilization reviews, norms for treatment, and systems for allocating resources (Ellwood 1988; Caper 1988). Putting contracts out for bid once again, institutional buyers have prompted doctors, clinics, and hospitals to assume new corporate forms and restructure

services. The center of power in American health care is now shifting from the profession to buyers.

Aspects of deprofessionalization have also evolved in part from the excesses and deficiencies of a professionally driven health care system. We have already described the bureaucratic and corporate dimensions. From a patient's point of view, the professional emphasis on ever more specialization results in fragmented care and a dehumanizing emphasis on technology. More than ever before, consumers are wary of overmedicalization, keen on reading about medicine, and determined to control what is done to their bodies. Meanwhile, the profession has displayed little interest in prevention and chronic care. The first does not involve sick patients, and the second consists of sick patients who do not respond well to treatment. Such excesses and deficiencies have contributed to the consumer health movement with its emphasis on enpowerment and staying well.

Thus, viewed historically, the four principal concepts about the medical profession are interconnected in ways that provide a new perspective distinct from that of Freidson. To remember wistfully the Golden Era of doctoring in the 1950s and 1960s is to forget how its features contributed to the current era.

The very notion of what it means to be professional is undergoing basic change. We must go beyond concepts of professionalism that emphasize autonomy (Carr-Saunders and Wilson 1933; Freidson 1970a, 1970b), or the loss of autonomy. A new framework is needed, one that incorporates historical trends and current features of the complex organizations and networks in which medical care is taking place (Schulz and Harrison 1986; Ellwood 1988).

References

Alexander, J.A., M.A. Morrisey, and S.M. Shortell. 1986. The Effects of Competition, Regulation, and Corporatization on Hospital-Physician Relationships. *Journal of Health and Social Behavior* 27:220–35.

Aquilina, D., J. Daley, and J. Coburn. 1987. Using Hospital Data to Spot Utilization Problems. *Business and Health* 4 (7):28–33.

Arney, W.R. 1982. *Power and the Profession of Obstetrics: Part 2.* Chicago: University of Chicago Press.

Aronowitz, S. 1973. *False Promises: The Shaping of American Working Class Consciousness.* New York: McGraw-Hill.

Avnet, H.H. 1944. *Voluntary Insurance in the United States: Major*

Trends and Current Problems. New York: Medical Administration Service.

Barnett, G.O., J.J. Cimino, A. Hupp, and E.P. Hoffer. 1987. DXplain: An Evolving Diagnostic Decision-Support System. *Journal of the American Medical Association* 258 (1):67–74.

Barzun, J. 1978. The Professions under Siege. *Harper's* (257):61–8.

Bell, D. 1973. *The Coming of Post-industrial Society*. New York: Basic Books.

———. 1976. *The Cultural Contradictions of Capital*. New York: Basic Books.

Berlant, J.L. 1975. Profession and Monopoly: *A Study of Medicine in the United States and Great Britain*. Berkeley: University of California Press.

Block, R.S. 1988. The Pressure to Keep Prices High at a Walk-in Clinic. *New England Journal of Medicine* 319 (12):785–87.

Burnham, J.F. 1984. The Unfortunate Care of Dr. Z: How to Succeed in Medical Practice in 1984. *New England Journal of Medicine* 310 (11):729–30.

Burris, V. 1987. Class Structure and Political Ideology. *Insurgent Sociologist* 14 (2):7–47.

Burrow, J.G. 1963. *AMA: Voice of American Medicine*. Baltimore: Johns Hopkins University Press.

———. 1977. *Organized Medicine in the Progressive Era: The Move toward Monopoly*. Baltimore: Johns Hopkins University Press.

Caper, P. 1988. Defining Quality in Medical Care. *Health Affairs* 7 (1):49–61.

Caplan, R.L. 1981. Pasturized Patients and Profits: The Changing Nature of Self-care in American Medicine. Unpublished Ph.D. diss., Department of Economics, University of Massachusetts.

Carchedi, G. 1977. *On the Economic Identification of Social Classes*. London: Routledge and Kegan Paul.

Carr-Saunders, A.M., and P.A. Wilson. 1933. *The Professions*. Oxford: Clarendon Press.

Chernomas, R. 1986. An Economic Basis for the Proletarianization of Physicians. *International Journal of Health Services* 16 (4):669–74.

Coburn, D., G.M. Torrance, and J. Kaufert. 1983. Medical Dominance in Canada in Historical Perspective: Rise and Fall of Medicine? *International Journal of Health Services* 13 (3):407–32.

Derber, C. 1982. *Professionals as Workers: Mental Labor in Advanced Capitalism*. Boston: G.K. Hall.

———. 1983. Sponsorship and the Control of Physicians. *Theory and Society* 12:561–601.

Ehrenreich, B., and J. Ehrenreich. 1977. The Professional-Managerial Class. *Radical America* 11 (2):7–32.

Ellwood, P.M. 1988. Shattuck Lecture: Outcomes Management. *New England Journal of Medicine* 318 (23):1549–1556.

Fein, R. 1986. *Medical Care, Medical Costs: The Search for a Health Insurance Policy.* Cambridge: Harvard University Press.

Feldstein, P.J., T.M. Wickizer, and J.R.C. Wheeler. 1988. Private Cost Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures. *New England Journal of Medicine* 318 (20):1310–14.

Ferguson, C.W. 1937. *Fifty Million Brothers: A Panorama of American Lodges and Clubs.* New York: Farrar and Rinehart.

Freidson, E. 1961. *Patients' Views of Medical Practice.* New York: Russell Sage Foundation.

———. 1968. The Impurity of Professional Authority. In *Institutions and the Person,* ed. H.S. Becker, B. Geer, D. Riesman, and R.S. Weiss, 25–34. Chicago: Aldine.

———. 1970a. *Professional Dominance: The Social Structure of Medicine.* New York: Atherton.

———. 1970b. *Profession of Medicine.* New York: Dodd, Mead.

———. 1984. The Changing Nature of Professional Control. *Annual Review of Sociology* 10:1–20.

———. 1985. The Reorganization of the Medical Profession. *Medical Care Review* 42:11–35.

———. 1986a. The Medical Profession in Transition. In *Applications of Social Science to Clinical Medicine and Health Policy,* ed. L. Aiken and D. Mechanic, 63–79. New Brunswick: Rutgers University Press.

———. 1986b. *Professional Powers: A Study of the Institutionalization of Formal Knowledge.* New Brunswick: Rutgers University Press.

Fruen, M.A. 1986. *Health Care in the Future.* Boston: John Hancock Mutual Life Insurance Co.

Gabel, J., C. Jaiich-Toth, K. Williams, S. Loughran, and K. Haugh. 1987. The Commercial Health Insurance Industry in Transition. *Health Affairs* 6 (3):46–60.

Goldfinger, S.E. 1987. A Matter of Influence. *New England Journal of Medicine* 316 (22):1408–9.

Goldman, L., E.F. Cook, D.A. Brand, T.H. Lee, G.W. Rouan, M.C. Weisberg, D. Acampora, C. Stasiulewicz, J. Walshon, G. Terranova, L. Gottlieb, M. Kobernick, B. Goldstein-Wayne, D. Coper, K. Daley, A.A. Brandt, D. Jones, J. Mellors, and R. Jakubowski. 1988. A Computer Protocol to Predict Myocardial

Infarction in Emergency Department Patients with Chest Pain. *New England Journal of Medicine* 318 (13):797–803.

Goldsmith, J.C. 1984. Death of Paradigm: The Challenge of Competition. *Health Affairs* 3 (3):5–19.

Goldstein, M.S. 1984. Abortion as a Medical Career Choice: Entrepreneurs, Community Physicians, and Others. *Journal of Health and Social Behavior* 25:211–229.

Greenberg, E.R., C.G. Chute, T. Stukel, J.A. Baron, D.H. Freeman, J. Yates, and R. Korson. 1988. Social and Economic Factors in the Choice of Lung Cancer Treatment. *New England Journal of Medicine* 318 (10):612–17.

Greenspan, A.M., H.R. Kay, B.C. Berger, R.M. Greenberg, A.J. Greenspon, and M.J. Spuhler Gaughan. 1988. Incidence of Unwarranted Implantation of Permanent Cardiac Pacemakers in a Large Medical Population. *New England Journal of Medicine* 318 (3):158–63.

Haug, M.R. 1973. Deprofessionalization: An Alternate Hypothesis for the Future. *Sociological Review Monograph* 20:195–211.

———. 1976. The Erosion of Professional Authority: A Cross-cultural Inquiry in the Case of the Physician. *Milbank Memorial Fund Quarterly/Health and Society* 54:83–106.

Haug, M.R., and B. Lavin. 1981. Practitioner or Patient: Who's in Charge? *Journal of Health and Social Behavior* 22:212–29.

———. and B. Lavin. 1983. *Consumerism in Medicine: Challenging Physician Authority.* Beverly Hills: Sage.

Henderson, C.R. 1909. *Industrial Insurance in the United States.* Chicago: University of Chicago Press.

Inlander, C.B. 1987. Consumers Can Put Health Care Data to Good Use. *Business and Health* 4 (7):26–27.

Kennedy, F.R. 1954. The American Medical Association: Power, Purpose, and Politics in Organized Medicine. *Yale Law Journal* 63 (7):938–1022.

King, S., and C. Skinner. 1984. Evaluating Utilization Review. *Business and Health* 1 (9):40–42.

Larkin, G. 1983. *Occupational Monopoly and Modern Medicine.* London: Tavistock.

Larson, M.S. 1977. *The Rise of Professionalism: A Sociological Analysis.* Berkeley: University of California Press.

Larson, M.S. 1980. Proletarianization and Educated Labor. *Theory and Society* 9:131–75.

Leland, R.G. 1932. *Contract Practice.* Chicago: American Medical Association.

Lexchin, J. 1987. Pharmaceutical Promotion in Canada: Convince Them or Confuse Them. *International Journal of Health Services* 17 (2):77–89.

Lieberman, J.K. 1970. *The Tyranny of Experts*. New York: Walker.

Light, D.W. 1974. Professional Superiority. Paper presented at the annual meeting of the American Sociological Association, Montreal, August 27.

———. 1979. Uncertainty and Control in Professional Training. *Journal of Health and Social Behavior* 20 (4):310–22.

———. 1986. Corporate Medicine for Profit. *Scientific American* 255 (6):38–45.

———. 1988a. Social Control and the American Health Care System. In *Handbook of Medical Sociology*, ed. H.E. Freeman and S. Levine. Englewood Cliffs, N.J.: Prentice-Hall. (Forthcoming.)

———. 1988b. Turf Battles and the Theory of Professional Dominance. In *Research in the Sociology of Health Care*, vol. 7, 203–25. Greenwich, Conn.: JAI Press.

Light, D.W., and A. Schuller. 1986. *Political Values and Health Care: The German Experience*. Cambridge: MIT Press.

McCleery, R.S., L.T. Kelly, M. Lam, R.E. Phillips, and T.M. Quirin. 1971. *One Life-One Physician: An Inquiry into the Medical Profession's Performance in Self-regulation*. Washington: Public Affairs Press.

McKinlay, J.B. 1977. The Business of Good Doctoring or Doctoring as Good Business: Reflections on Freidson's View of the Medical Game. *International Journal of Health Services* 7 (30):459–87.

McKinlay, J.B., and J. Arches. 1985. Toward the Proletarianization of Physicians. *International Journal of Health Services* 15 (2):161–95.

———. 1986. Historical Changes in Doctoring: A Reply to Milton Roemer. *International Journal of Health Service* 16 (3):473–77.

McKinlay, J.B., and J.D. Stoeckle. 1988. Corporatization and the Social Transformation of Doctoring. *International Journal of Health Services* 18 (2):191–205.

Mintz, M. 1967. *By Prescription Only*. 2nd ed. Boston: Houghton Mifflin.

National Industrial Conference Board. 1923. *Experience with Mutual Benefit Associations in the United States*. New York.

Navarro, V. 1976. *Medicine under Capitalism*. New York: Prodist.

———. 1986. *Crisis, Health and Medicine*. New York: Tavistock.

———. 1988. Professional Dominance or Proletarianization?: Neither. *Milbank Quarterly* 66 (Suppl. 2):57–75.

O'Donnell, P.S. 1987. Managing Health Costs Unicer a Fee-for-service Plan. *Business and Health* 4 (5):23–29.

Ollier, C. 1987. The Data Connection. *Health Week* 1 (8):22, 26–27.

Oppenheimer, M. 1970. White Collar Revisited: The Making of a New Working Class. *Social Policy* 1 (July-Aug.):27–32.

———. 1975. The Unionization of the Professional. *Social Policy* 5 (Jan.-Feb.):34–40.

———. 1985. *White Collar Politics.* New York: Monthly Review Press.

Parsons, T. 1951. *The Social System.* Glencoe, Ill.: Free Press.

———. 1954. *Essays in Sociological Theory.* Rev. ed. Glencoe, Ill.: Free Press.

Poulantzas, M. 1975. *Classes in Contemporary Capitalism.* London: New Left Books.

Rayack, E. 1967. *Professional Power and American Medicine: The Economics of the American Medical Association.* Cleveland: World.

Relman, A.S. 1980. The New Medical-Industrial Complex. *New England Journal of Medicine* 303 (17):963–70.

———. 1985. Dealing with Conflicts of Interest. *New England Journal of Medicine* 313 (12):749–51.

Rennels, G.D., and E.H. Shortliffe. 1987. Advanced Computing for Medicine. *Scientific American* 257 (4):154–61.

Rensberger, B. 1988. Thousands a Year Killed by Prescriptions. *New York Times,* Jan. 28.

Ricks, T.E. 1987. New Corporate Program Lets Employees Compare Local Doctors' Fees and Training. *Wall Street Journal* (Aug. 4):37.

Roemer, M.I. 1986. Proletarianization of Physicians or Organization of Health Services? *International Journal of Health Services* 16 (3):469–72.

Rorem, C.R. 1940. *Non-Profit Hospital Service Plans.* Chicago: Commission on Hospital Service, American Hospital Association.

Rorem, C.R., and R.P. Fischelis. 1932. *The Costs of Medicine.* Chicago: University of Chicago Press.

Rosenberg, C.E. 1987. *The Care of Strangers: The Rise of America's Hospital System.* New York: Basic Books.

Rosner, D.A. 1982. *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1855–1915.* New York: Cambridge University Press.

Rosoff, A. J. 1979. Antitrust Laws and the Health Care Industry: New Warriors into an Old Battle. *St. Louis University Law Journal* 446:458–89.

Rothstein, W.G. 1972. *American Physicians in the Nineteenth Century.* Baltimore: Johns Hopkins University Press.

———. 1987. *American Medical Schools and the Practice of Medicine: A History.* New York: Oxford University Press.

Rueschemeyer, D. 1986. *Power and the Division of Labor.* Stanford: Stanford University Press.

Sarason, S. 1977. *Work, Aging, and Social Change.* New York: Free Press.

Schulz, R., and S. Harrison. 1986. Physician Autonomy in the Federal Republic of Germany, Great Britain and the United States. *International Journal of Health Planning and Management* 2:336–55.

Scovern, H. 1988. Hired Help: A Physician's Experience in a For-profit Staff-model HMO. *New England Journal of Medicine* 319 (12):787–90.

Scull, A.T. 1979. *Museums of Madness: The Social Organization of Insanity in Nineteenth-century England.* New York: St. Martin Press.

Shortell, S.M. 1983. Physician Involvement in Hospital Decision Making. In *The New Health Care for Profit,* ed. B.H. Gray, 73–101. Washington: National Academic Press.

Shortell, S.M., M.A. Morrisey, and D.A. Conrad. 1985. Economic Regulation and Hospital Behavior: The Effects on Medical Staff Organization and Hospital-Physician Relationships. *Health Services Research* 20 (5):597–628.

Shortliffe, E.H. 1987. Computer Programs to Support Clinical Decision Making. *Journal of the American Medical Association* 258 (1):61–66.

Starr, P. 1982. *The Social Transformation of American Medicine.* New York: Basic Books.

Stevens, R. 1971. *American Medicine and the Public Interest.* New Haven: Yale University Press.

Stoeckle, J.D. 1988. Reflections on Modern Doctoring. *Milbank Quarterly* 66 (Suppl. 2):76–91.

Vogel, M. 1980. *The Invention of the Modern Hospital, Boston, 1870–1930.* Chicago: University of Chicago Press.

Waitzkin, H. 1983. *The Second Sickness: Contradictions of Capitalist Health Care.* New York: Free Press.

Waitzkin, H., and B. Waterman. 1976. Social Theory and Medicine. *International Journal of Health Services* 6 (1):9–23.

Walsh, D.C. 1987. *Corporate Physicians: Between Medicine and Management.* New Haven: Yale University Press.

Weber, M. 1968. *Economy and Society: An Outline of Interpretive Sociology.* New York: Bedminster Press.

Williams, P. 1932. *The Purchase of Medicinal Care through Fixed Periodic Payments.* New York: National Bureau of Economic Research.

Willis, E. 1983. *Medical Dominance: The Division of Labour in Australian Health Care.* Sydney: Allen and Unwin.

Wilsford, D. 1987. The Cohesion and Fragmentation of Organized Medicine in France and the United States. *Journal of Health Politics, Policy and Law* 12 (3):481–503.

Wright, E.O. 1978. *Class, Crisis and the State.* London: New Left Books.

———. 1980. Varieties of Marxist Conceptions of Class Structure. *Politics and Society* 9 (3):323–70.

———. 1985. *Classes.* London: New Left Books.

Acknowledgments: We greatly appreciate the critical reviews by Frederick Hafferty, Vicente Navarro, and Cecil Sheps; remaining flaws redound to us. The research underlying this essay is part of a study sponsored by the Twentieth Century Fund. We appreciate their support and that of the Kaiser Family Foundation.

Address correspondence to: Donald W. Light, Ph.D., Department of Psychiatry, University of Medicine and Dentistry of New Jersey/SOM, 401 Haddon Avenue, Camden, NJ 08103.